BILL LOCKYER, Attorney General
of the State of California
ADRIAN K. PANTON, State Bar No. 64459
Supervising Deputy Attorney General
ELAINE M. GYURKO
Senior Legal Analyst
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-4944
Facsimile: (213) 897-9395

Attorneys for Complainant

BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JOLLY M. CYRIAC 11782 Palo Verde Avenue Cerritos, CA 90703 Respiratory Care Practitioner License No. 23089 Respondent.	Case No. R-1951 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Stephanie Nunez (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Respiratory Care Board of California, Department of Consumer Affairs.

2. On or about August 1, 2003, the Respiratory Care Board issued Respiratory Care Practitioner License Number 23089 to Jolly M. Cyriac (Respondent). This license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2006, unless renewed.

JURISDICTION

3. This Accusation is brought before the Respiratory Care Board (Board), Department of Consumer Affairs, under the authority of the following laws. All section references

are to the Business and Professions Code unless otherwise indicated.

4. Section 3710 of the Code states: "The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter [Chapter 8.3, the Respiratory Care Practice Act]."

5. Section 3718 of the Code states: "The board shall issue, deny, suspend, and revoke licenses to practice respiratory care as provided in this chapter."

6. Section 3750 of the Code states:

"The board may order the denial, suspension or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

" . . .

"(f) Negligence in his or her practice as a respiratory care practitioner.

" . . .

"(o) Incompetence in his or her practice as a respiratory care practitioner. . . ."

7. Section 3755 of the Code states:

"The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care. Unprofessional conduct includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision of Section 3750. The board may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner."

COST RECOVERY

8. Section 3753.5, subdivision (a) of the Code states:

"In any order issued in resolution of a disciplinary proceeding before the board, the board or the administrative law judge may direct any practitioner or applicant found to have committed a violation or violations of law to pay to the board a sum not to exceed the costs of the

investigation and prosecution of the case."

9. Section 3753.7 of the Code states:

"For purposes of the Respiratory Care Practice Act, costs of prosecution shall include attorney general or other prosecuting attorney fees, expert witness fees, and other administrative, filing, and service fees."

10. Section 3753.1, subdivision (a) of the Code states:

"An administrative disciplinary decision imposing terms of probation may include, among other things, a requirement that the licensee-probationer pay the monetary costs associated with monitoring the probation."

FIRST CAUSE FOR DISCIPLINE

(Negligence)

11. Respondent is subject to disciplinary action under section 3750, subdivision (f) of the Code, in that she was negligent in her practice as a respiratory care practitioner. The circumstances are as follows:

A. In August 2003, respondent was employed as a respiratory care practitioner at St. Mary Medical Center in Long Beach. On or about August 20, 2003, respondent was responsible for providing respiratory care and treatment to patient P.Q., an eighty-four year-old female ventilator dependent patient who required dialysis because of kidney failure. At about 1:15 p.m., respondent transported the patient and her ventilator from the subacute unit to the hemodialysis unit for kidney failure treatment. Respondent then placed the patient on the ventilator, but did not turn on the ventilator. She did not ensure the ventilator was functioning properly after the transport. Respondent did not assess the condition of the patient after transporting her to the dialysis unit and placing her on the ventilator. She did not document the transport of patient P.Q. She did not document on the ventilator flowsheet that she verified the ventilator settings and alarm settings after the transport. She did not document the patient's condition after she was transported to the dialysis unit and placed on the ventilator.

B. On August 20, 2003, Respondent did not administer to P.Q. the

breathing medications Albuterol and Atrovent every four hours as ordered by her physician. She gave the first dose of medication at 7:25 a.m., but did not give the patient any further breathing treatments for the remainder of the day.

C. About three hours later, the patient was found to have low blood pressure and did not respond to fluids that were given to her. The nurse who received patient P.Q. discovered the ventilator was off. The nurse proceeded to manually ventilate the patient and paged respondent. Respondent did not respond to the unit, but instead asked another respiratory therapist to respond. When the second therapist came to the patient's room, she also found the ventilator was in the off position. The second therapist turned on the ventilator, but P.Q.'s condition had deteriorated and she expired later that day.

D. On August 21, 2003, a usage summary report and an events log report were downloaded from the ventilator that had been connected to P.Q. The usage summary report indicated that on August 20, 2003, P.Q.'s ventilator was on until 1:07 p.m. and then was off for about three hours until 4:06 p.m. The events log report indicated P.Q. was on the ventilator at 1:07:19 p.m., but at 1:07:36 p.m., the ventilator mode changed from synchronized intermittent mandatory ventilation (SIMV) to standby (STBY). This occurred when respondent disconnected the patient from the ventilator for her transfer to the dialysis unit. At 1:09 p.m., the AC switched to internal battery alarm when the power was unplugged. The ventilator remained in standby mode until 4:16 p.m. when P.Q. was reconnected to the ventilator by another respiratory therapist who found the ventilator in the off position.

Negligent Acts

E. Respondent committed acts of negligence regarding the care and treatment of P.Q. which included, but were not limited to, the following:

(1) Respondent failed to turn on the ventilator after transporting the patient from the subacute unit to the hemodialysis unit which resulted P.Q. being off the ventilator for three hours.

(2) Respondent failed to ensure that the mechanical ventilator was functioning properly after the transfer. She failed to ensure the ventilator mode was switched from standby mode to SIMV mode. She failed to ensure that the alarms were properly set, and that she was utilizing the appropriate settings according to the physician's orders.

(3) Respondent failed to assess the condition of the patient after transporting her to the dialysis unit.

(4) Respondent failed to document the transport of the patient.

(5) Respondent failed to document on the ventilator flowsheet that she verified the ventilator settings and alarm settings after transferring the patient from one unit to another.

(6) Respondent failed to document the condition of the patient after transporting her to the dialysis unit.

(7) Respondent failed to administer the breathing medications Albuterol and Atrovent every four hours as ordered by the physician.

(8) Respondent failed to provide the patient with proper care and treatment, which caused the patient's condition to deteriorate after being off the ventilator for three hours and ultimately resulted in the patient's death.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

12. Respondent is subject to disciplinary action under section 3750, subdivision (o) of the Code, in that she was incompetent in her practice as a respiratory care practitioner. The facts and circumstances, set forth in Paragraph 11 of this Accusation, are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Respondent is subject to disciplinary action under section 3755 of the Code, in that she engaged in unprofessional conduct in her practice as a respiratory care practitioner. The

facts and circumstances, set forth in Paragraph 11 of this Accusation, are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Respiratory Care Board issue a decision:

1. Revoking or suspending Respiratory Care Practitioner License Number 23089, issued to Jolly M. Cyriac.

2. Ordering Jolly M. Cyriac to pay the Respiratory Care Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

3. Taking such other and further action as deemed necessary and proper.

DATED: October 7, 2004

Original signed by Liane Zimmerman for:
STEPHANIE NUNEZ
Executive Officer
Respiratory Care Board of California
Department of Consumer Affairs
State of California
Complainant